



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-17-3110-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

June 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: \$316.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The office will maintain our denial for this service for 97-payment is included in the allowance for another service/procedure as CPT code 96374 and CPT code 25000 have been found to be in conflict pursuant to the NCCI edits."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2017	96374	\$316.96	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following adjustment codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - W3 – Additional payment made on appeal/reconsideration

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
- 4915 – The charge for the services represented by the revenue care are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is package or excluded from payment.

Issues

1. What is the applicable rule that applies to reimbursement?

Findings

1. The requestor is seeking \$316.96 for Code 96374 rendered on April 6, 2017.

The insurance carrier denied Code 96374 with adjustment reason code 97 – “Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”

The Division Rule that applies to Outpatient Hospital Services is found at 28 Texas Administrative Code §134.403. Section 134.403 (b) (3) and (d) states in pertinent part,

(b)(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare

and

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided.

Review of the Medicare NCCI procedure to procedure (PTP) edits found at;

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html> finds an edit exists between Code 25000 and 96374. Therefore the carrier’s denial is supported. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 19, 2017
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.